ASSEMBLY BILL No. 2979

Introduced by Assembly Member Richman

February 24, 2006

An act to add Section 14087.49 to, to add and repeal Section 14499.80 of, and to add and repeal Article 9 (commencing with Section 14499.90) of Chapter 8 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2979, as introduced, Richman. Medi-Cal.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

This bill would authorize the department to establish a pilot program, commencing April 1, 2008, in up to 2 counties, that would require that certain eligible seniors and persons with disabilities shall be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans.

This bill would also, until January 1, 2013, authorize the department to implement the Access Plus plan as a pilot program to enable eligible individuals in selected counties to receive a continuum of services in selected participating counties, to explore more flexible managed care models that include services authorized under the federal Medicaid Program and the federal Medicare Program.

This bill would also, until January 1, 2013, authorize the department to implement the Access Plus Community Choices plan to enable

eligible individuals in selected counties to receive a continuum of services that maximizes community living.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $^2/_3$. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14087.49 is added to the Welfare and Institutions Code, to read:

14087.49. (a) For purposes of this section, the following definitions shall apply:

(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.91 (commencing with Section 14089) of this chapter or Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8 (commencing with Section 14200).

(2) "Medi-Cal managed care health plan" means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter or Chapter 8 (commencing with Section 14200).

(3) "Seniors and persons with disabilities" means Medi-Cal beneficiaries eligible for benefits through age, blindness, or disability, as defined in Title XVI of the Social Security Act (42 U.S.C. Sec. 1381 et seq.).

(4) "Excluded persons" means persons who are simultaneously qualified for full benefits under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.), persons who are eligible for Medi-Cal with a share of cost (except to the extent these persons are made mandatory enrollees in a Medi-Cal managed care health plan under Article 2.8 (commencing with Section 14087.5), and persons who at the time they are to be mandatorily enrolled are either on a major organ, except kidney, transplant list or in one of the following home- and

community-based waivers under Section 1396n of Title 42 of the United States Code:

(A) In-Home Medical Care Waiver.

(B) Nursing Facility Subacute Waiver.

(C) Nursing Facility Level A/B Waiver.

(b) Notwithstanding subparagraph (B) of paragraph (1) of subdivision (c) of Section 14089, and paragraph (3) of subdivision (b) of Section 53845 of, subparagraph (A) of paragraph (3) of subdivision (b) of Section 53906 of, and subdivision (a) of Section 53921. of, Title 22 of the California Code of Regulations, the department may, commencing April 1, 2008, establish a pilot program as described in Section 14490 in up to two counties to require that seniors and persons with disabilities who are not excluded persons be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans authorized by Article 2.7 (commencing with Section 14087.3) or Article 2.91 (commencing with Section 14089). Access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care provider.

(c) Prior to exercising its authority pursuant to subdivision (b), the department, in consultation with affected stakeholders, shall do all of the following:

(1) Assess and ensure the readiness of the health care options enrollment system to adequately address the unique needs of seniors and persons with disabilities.

(2) Develop and implement an outreach and education program to seniors and persons with disabilities to inform them of their enrollment options and rights under the pilot program.

(3) Implement an appropriate awareness and sensitivity training program for all staff in the Office of the Medi-Cal Managed Care Ombudsman.

(4) Coordinate with Medi-Cal managed care health plans selected for the pilot program to develop and implement a mutually acceptable mechanism to identify, within the earliest possible timeframe, persons with special health care needs, particularly seniors and persons with disabilities.

(5) Provide Medi-Cal managed care health plans involved in the pilot program with a list containing the names of fee-for-service providers that are providing services to beneficiaries who are to be enrolled in a managed care health

plan so Medi-Cal managed health care plans involved in the pilot program may use this data to assist beneficiaries in continuing their existing provider-patient relationships.

(6) Develop and provide Medi-Cal managed care health plans selected for the pilot program with a checklist for use in meeting the requirements of the Americans with Disabilities Act.

(7) Convene a stakeholder process in those counties designated for the pilot program at least four months prior to the enrollment of seniors and persons with disabilities. Stakeholders may include, but not be limited to, persons with disabilities, seniors, Medi-Cal managed care health plans, physicians, hospitals, children's hospitals, consumer advocates, disability advocates, county or University of California hospitals, and exclusive collective bargaining agents for hospital workers of affected hospitals.

(8) Have a process to enforce all legal sanctions, including, but not limited to, financial penalties, withholds, enrollment termination, and contract termination, in order to sanction any Medi-Cal managed care health plan involved in the pilot program that fails to meet performance standards.

(9) Require that all Medi-Cal managed care plans involved in the pilot program submit all required contract deliverables and have demonstrated that they have satisfactorily met department standards.

(10) Require that the primary services for the pilot programs include access to reproductive services, including procedures for providing female seniors and females with disabilities with direct access to an obstetrician-gynecologist to provide women's routine and preventive health care services, and that ensure that pregnant women with disabilities at a high risk of poor pregnancy outcome for the mother or the child are referred to appropriate specialists, including perinatologists, and have access to genetic screening with appropriate referrals.

(11) Ensure that the pilot program provides an opportunity for members to select a specialist as a primary care provider as defined in subdivision (ff) of Section 53810 of Title 22 of the California Code of Regulations.

(12) Ensure that the pilot program makes reasonable efforts to provide seniors and persons with disabilities with access to the following services:

(A) Inpatient and outpatient rehabilitation services through providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), or other similar accreditation organization.

(B) Applied rehabilitative technology.

(C) Speech pathologists, including those experienced in working with significant speech impairment, persons with developmental disabilities, and persons who require augmentative communication devices.

(D) Occupational therapy, orthotic providers.

(E) Physical therapy.

(F) Low-vision centers.

(G) Other services with expertise in working with seniors and persons with disabilities.

(13) Ensure that Medi-Cal managed care health plans involved in the pilot program provide access to assessments and evaluations for wheelchairs that are independent of durable medical equipment providers and include, when necessary, a home assessment.

(14) Ensure that Medi-Cal managed care health plans involved in the pilot program are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that assure communication, including assistive listening systems, sign language interpreters, captioning, pad and pencil, or written translations and oral interpreters, including for those who are limited English-proficient, and that all such Medi-Cal managed care health plans are in compliance with the cultural and linguistic requirements set forth in subdivision (c) of Section 53853 and Section 53876 of Title 22 of the California Code of Regulations.

(15) Ensure that Medi-Cal managed care health plans involved in the pilot program provide access to out-of-network providers for individual seniors and persons with disabilities members who have an ongoing relationship with such a provider, if the provider will accept the rates offered by the plan, and the plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(d) The department may establish advisory boards composed of, but not limited to, Medi-Cal managed care health plans, Medi-Cal beneficiaries, consumer representatives, disability

advocates, health care professionals, local officials, county departments, labor union representatives, and legislative representatives, that shall consult and advise the department with respect to the planning, implementation, and operation of mandatory enrollment of seniors and persons with disabilities in the pilot program.

(e) Prior to exercising its authority pursuant to subdivision (b) and after consultation with affected stakeholders, the department shall ensure that each Medi-Cal managed care health plan involved in the pilot program is able to do all of the following:

(1) Comply with the applicable readiness evaluation requirements set forth in Section 14087.48, and other applicable readiness requirements set forth in Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Title 22 of the California Code of Regulations.

(2) Ensure an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of facilities within each service area.

(3) Assess the health care needs of beneficiaries who are seniors and persons with disabilities and coordinate their care across all settings, including coordination of discharge to necessary services within and, where necessary, outside of the plan's provider network.

(4) Comply with relevant federal and state statutes and regulations to ensure access for seniors and persons with disabilities.

(5) Ensure timely access, and where appropriate, standing referrals to specialists within or, where necessary, outside of the plan's provider network, including pediatric specialists, subspecialists, speciality care centers, ancillary therapists, and specialized equipment and supplies, including durable medical equipment.

(6) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner, maintaining toll-free phone lines, and offering member or ombudsmen services.

(7) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests,

including procedures for appealing decisions regarding coverage or benefits. Each plan involved in the pilot program shall have a grievance process that complies with Sections 1368 and 1368.01 of the Health and Safety Code.

(8) Ensure stakeholder and member participation in advisory groups for the planning and development activities related to provision of services for seniors and persons with disabilities.

(9) Contract with traditional and safety net providers to ensure access to care and services.

(10) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.

(11) Monitor and improve the quality and appropriateness of care for children with special health care needs, including children eligible for or enrolled in the California Children Services Program (CCS), and seniors and persons with disabilities.

(f) Beneficiaries or eligible applicants enrolled in Medi-Cal managed care plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a Medi-Cal managed care health plan involved in the pilot program if his or her treating provider is a primary care provider or clinic contracting with the Medi-Cal managed care health plan and has available capacity and agrees to continue to treat that beneficiary.

(g) Beneficiaries or eligible applicants enrolled in Medi-Cal managed care plans shall have access to the department's medical exemption process to address the health care of seniors and persons with disabilities, as set forth in Section 53887 of Title 22 of the California Code of Regulations.

(h) The department, or as applicable, the commission, may contract with existing Medi-Cal managed care health plans operating in a pilot project county to provide or arrange for services under this section. Notwithstanding Sections 14087.3 and 14089 and Sections 53800 and 53900 of Title 22 of the California Code of Regulations, the department, or as applicable, the commission, may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the Medi-Cal managed care health plan demonstrates it meets all qualifications and requirements of this section.

Alternatively, the department, or as applicable, the commission, may seek applications and then contract with any qualified individual, entity, or organization to provide or arrange for services under this section. The application process shall be similar to the process used in the Geographic Managed Care Program under Article 2.91 (commencing with Section 14089).

(i) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section and obtain any federal waivers necessary to allow for federal financial participation. This section shall be implemented only to the extent that federal financial participation is available.

(j) The development and negotiation of capitation rates for Medi-Cal managed care health plan contracts shall involve the analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing or negotiating capitation rates for payments to Medi-Cal managed care health plans, the director may require Medi-Cal managed care health plans, including existing Medi-Cal managed health care plans, to submit financial and utilization data in a form and substance as deemed necessary by the department.

(k) Nothing in this section is intended to limit existing authority, including the authority of the commission, as set forth in Article 2.8 (commencing with Section 14087.5) or Article 2.91 (commencing with Section 14089).

(*l*) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) may select a PACE plan if one is available in that county.

(m) Nothing in this section shall imply changes to existing services carved out of Medi-Cal managed care health plans in the pilot counties.

(n) Services covered by the California Children’s Services Program shall be governed in this Medi-Cal managed care expansion as set forth in this section in a manner that is consistent with Article 2.98 (commencing with Section 14094).

(o) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of county letters, plan letters, plan or provider bulletins, or similar instructions.

(p) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and in order to achieve maximum costs savings, the Legislature hereby determines that an expedited contract process is necessary for Medi-Cal managed care plan contracts entered into or amended pursuant to this section. These contracts and amendments shall be exempt from Chapter 2 (commencing with Section 10290 of Part 2 of Division 2 of the Public Contract Code and the requirements of State Administrative Management Manual Memo 03-10.

SEC. 2. Section 14499.80 is added to the Welfare and Institutions Code, to read:

14499.80. (a) The department may implement Access Plus plans as a pilot program to enable individuals to receive a continuum of services in selected participating counties. The pilot program may be conducted to explore more flexible managed care models that include services authorized under the federal Medicaid Program (Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and federal Medicare Program (Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.)).

(b) For purposes of this section, the following definitions shall apply:

(1) “Contracting entity” means a managed care health plan responsible for providing, or arranging and paying for the provision of, integrated medical benefits to eligible persons pursuant to the requirements of this section.

(2) “Dual eligible” means any person who is simultaneously qualified for full benefits under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) “Eligible population” means dual eligible Medi-Cal beneficiaries.

(c) Consistent with the provisions of this section, the director may establish, in consultation with the federal Centers for Medicare and Medicaid Services, and administer a federally approved project that integrates Medicare and Medi-Cal medical benefits. The project established under this section shall be known as Access Plus. The department shall take all appropriate

steps to amend the state plan, if necessary, to carry out this section and obtain any federal waivers to allow for federal financial participation. This section shall be implemented only to the extent that federal financial participation is available.

(d) The director may select counties in which to implement Access Plus pilot projects and contract with qualified contracting entities selected through the department's application process. The director shall not enter into contracts with any Access Plus contracting entities until all necessary federal approvals are obtained.

(e) Contracting entities may be selected to provide or arrange and pay for comprehensive medical services that integrate components of care and services covered pursuant to this section, either directly or through subcontracts.

(f) (1) A contracting entity pursuant to this section shall be licensed by the Department of Managed Health Care. In their application to the program, those entities that are licensed by the Department of Managed Health Care shall provide assurance that they are in good standing with that department.

(2) A contracting entity shall be either a Medicare Advantage Plan with prescription drug coverage or a Medicare Special Needs Plan, or any other designated risk-based Medicare managed care plan established by the Centers for Medicare and Medicaid Services, that will provide both Medicare benefits and Medicare prescription drug coverage and Medi-Cal benefits.

(3) A contracting entity shall demonstrate the ability to provide, either directly or through subcontracts, Medicare and Medicaid covered services.

(g) Contracting entities shall meet all external quality review standards, as outlined in Subpart E (commencing with Section 438.320) of Title 42 of the Code of Federal Regulations.

(h) All Access Plus contracts and amendments or change orders thereto shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Further, the contracts, including any contract amendment or change order, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, except for Chapter 8 of that part and from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

(i) (1) Within 60 days of entering into a contract with the department, a contracting entity and local mental health plans in the contracting entity's contracting service area shall execute a memorandum of understanding for the coordination of services for members of the managed care health plan who need specialty mental health services. The State Department of Health Services and the State Department of Mental Health, in consultation with the California Mental Health Director's Association, shall jointly prepare a model memorandum of understanding to be used by contracting entities and local mental health plans to comply with this section.

(2) Within 60 days of entering into a contract with the department, a contracting entity and the local regional centers in the contracting entity's contracting service area shall execute a memorandum of understanding for the coordination of services for members of the managed care health plan with developmental disabilities. The State Department of Health Services and the State Department of Developmental Services shall jointly prepare a model memorandum of understanding to be used by contracting entities and local regional centers to comply with this section.

(j) Enrollment in an Access Plus health plan under this section shall be voluntary for the eligible population.

(k) Services covered by the California Children's Services Program shall be governed in this Medi-Cal managed care expansion as set forth in this section in a manner that is consistent with Article 2.98 (commencing with Section 14094) of Chapter 7.

(*l*) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute that is chaptered on or before January 1, 2013, extends or deletes that date.

SEC. 3. Article 9 (commencing with Section 14499.90) is added to Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 9. Access Plus Community Choices Plans

14499.90. (a) The department shall implement Access Plus Community Choices (A+CC) plans to enable individuals to receive a continuum of services that maximizes community

living. The pilot program shall be conducted to explore more flexible managed care models that include services authorized under the federal Medicaid Program (Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.)).

(b) For purposes of this section, the following definitions shall apply:

(1) "Contracting entity" means a managed care entity responsible for providing, or arranging and paying for the provision of, integrated medical and home- and community-based benefits to eligible persons pursuant to the requirements of this section.

(2) "Seniors and adult persons with disabilities" means individuals, years of age 21 or older, who otherwise are eligible for benefits through age, blindness, or disability as defined in Title XVI of the Social Security Act (42 U.S.C. Sec. 1381 et seq.).

(3) "Dual eligible" means any person who is simultaneously qualified for full benefits under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) "Eligible population" means seniors and adult persons with disabilities and dual eligible Medi-Cal beneficiaries.

(c) Consistent with the provision of this article, the director may establish, in consultation with the federal Centers for Medicare and Medicaid Services, and administer a federally approved project that integrates both Medicare and Medi-Cal funding streams, and integrates Medicare and Medi-Cal medical, and home- and community-based benefits. The project established under this section shall be known as Access Plus Community Choices (A+CC). The department shall take all appropriate steps to amend the state plan, if necessary, to carry out this section and obtain any federal waivers to allow for federal financial participation. This section shall be implemented only to the extent that federal financial participation is available.

(d) Notwithstanding subparagraph (B) of paragraph (1) of subdivision (c) of Section 14089 , and paragraph (3) of subdivision (b) of Section 53845 of, subparagraph (A) of paragraph (3) of subdivision (b) of Section 53906 of, and

subdivision (a) of Section 53921 of, Title 22 of the California Code of Regulations, the department may require that seniors and adult persons with disabilities be assigned as mandatory enrollees into Access Plus Community Choices (A+CC) health plans authorized by this article in up to two counties. One of the counties shall be a county that provides Medi-Cal managed care services under the Two-Plan Model pursuant to Article 2.8 (commencing with Section 14087.3) of Chapter 7. The other county shall be a county that provides Medi-Cal managed care services under the County Organized Health Systems model pursuant to Article 2.7 (commencing with Section 14087.5) of Chapter 7. The director may contract with qualified contracting entities to implement the Access Plus Community Choices pilot project. The director shall not enter into contracts with any Access Plus Community Choices contracting entities until all necessary federal approvals are obtained.

(e) Contracting entities shall be selected to provide or arrange and pay for comprehensive medical, and home- and community-based services that integrate components of care and services covered pursuant to this section, either directly or through subcontracts.

(f) (1) A contracting entity pursuant to this section shall be licensed by the Department of Managed Health Care and in good standing with that department.

(2) A contracting entity shall be either a Medicare Advantage plan with prescription drug coverage or a Medicare Special Needs Plan, or any other such designated risk-based Medicare managed care plan established by the Centers for Medicare and Medicaid Services that will offer Medicare benefits and Medicare prescription drug coverage as well as Medi-Cal medical, and home- and community-based services.

(3) A contracting entity shall demonstrate an ability to provide, either directly or through subcontracts, Medicare and Medicaid covered services. Contracts between the department and the contracting entities shall set forth the scope of Medi-Cal medical, and home- and community-based benefits, appropriate standards for serving the enrolled population, standards for home- and community-based provider networks, and quality standards developed by the department and approved by the federal Centers for Medicare and Medicaid Services.

(g) Contracting entities pursuant to this section shall be required to provide services that include, but are not limited to, the following:

(1) A care management system that incorporates consumer participation. The care management system shall include:

(A) Care management services that assist the member to navigate treatment settings; including, home, hospital, and nursing facility.

(B) Levels of care management services based on the assessed needs of each Access Plus Community Choices member.

(C) Person-centered care and service planning.

(D) Care-planning that maximizes independence, home- and community-based services, and diversion from institutional care.

(2) A comprehensive scope of benefits that includes all of the following:

(A) Long-term and short-term nursing facility care, excluding Intermediate Care Facilities for the Developmentally Disabled.

(B) Adult Day Health Care.

(C) Home- and community-based services.

(D) Full scope of Medi-Cal benefits except for services authorized and provided by regional centers, as defined in subdivision (j), and those coordinated services as specified in paragraph (3) of subdivision (f) and the In Home Supportive Services Program.

(E) Medicare benefits, including Part A, Part B, and Part D, for those enrollees who are Medicare-eligible.

(3) A system to coordinate with services not covered under the Access Plus Community Choices plan, including:

(A) The In-Home Supportive Services (IHSS) program.

(B) Services authorized by regional centers as specified in subdivision (j), for those who are eligible for regional center services.

(C) County specialty mental health services for those who are eligible.

(D) Independent Living Center services for those who are eligible.

(E) Older Americans Act and Older Californians Act services and supports.

(h) (1) Within 60 days of entering into a contract with the department, a contracting entity and local mental health plans in

the contracting entity's contracting service area shall execute a memorandum of understanding for the coordination of services for members of the managed care health plan who need specialty mental health services. The State Department of Health Services and the State Department of Mental Health, in consultation with the California Mental Health Director's Association, shall jointly prepare a model memorandum of understanding to be used by contracting entities and local mental health plans to comply with this section.

(2) Within 60 days of entering into a contract with the department, a contracting entity and the local regional centers in the contracting entity's contracting service area shall execute a memorandum of understanding for the coordination of services for members of the managed care health plan with developmental disabilities. The State Department of Health Services and the State Department of Developmental Services shall jointly prepare a model memorandum of understanding to be used by contracting entities and local regional centers to comply with this section.

(i) Contracting entities shall meet all external quality review standards, as outlined in Subpart E (commencing with Section 438.320) of Title 42 of the Code of Federal Regulations.

(j) All Access Plus Community Choices Plan contracts and amendments or change orders thereto shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Further, these contracts, including any contract amendment or change order, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

(k) The Access Plus Community Choices project shall not include or affect the following services and supports provided by regional centers established pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5, including, but not limited to, the following:

(1) Targeted Case Management State Plan Amendment under Sections 1905(a)(19) (42 U.S.C. Sec. 1396d(a)(19)) and 1915(g)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396n(g)).

(2) Section 1915(c) Home- and Community-based Services Waivers, Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)).

(3) Early Intervention Services for children under four years of age, provided for under Title 14 (commencing with Section 95000) of the Government Code and under Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.).

(4) Pre-Assessment, Screening-Resident Review, Nursing Home Reform under Section 1919(F) of the federal Social Security Act (42 U.S.C. Sec. 1396r).

(5) Any service and support provided by regional centers solely to active recipients of regional center services, but only for services that do not supplant the budget of any agency that has a legal responsibility to serve all members of the general public and are receiving public funds for providing those services under Section 4648, and for services that regional centers are responsible for pursuing funding as defined in subdivision (a) of Section 4659.

(*l*) This article shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute that is chaptered on or before January 1, 2013, extends or deletes that date.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2006 at the earliest possible time, it is necessary that this act take effect immediately.

O